STATE OF COLORADO
DEPARTMENT OF HUMAN SERVICES
DIVISION FOR DEVELOPMENTAL DISABILITIES

APPLICATION FOR PROGRAM APPROVAL – Level 1 Providers

Instructions:

Please read through the application thoroughly and complete all items. Incomplete applications will not be processed. Submit the completed Initial Program Approval application and required documents to:

The Division for Developmental Disabilities
Attention: Candie Dalton
4055 South Lowell Boulevard
Denver, CO 80236

Applications will not be accepted via email or fax. Please allow **30 business days** for DDD to review and process the application. After the application has been reviewed DDD will notify the agency in writing of the application status.

In addition to receiving Initial Program Approval from DDD the agency must enroll in the Colorado Medical Assistance Program and obtain a Medicaid Provider Number. Once the agency receives a Medicaid Provider Number DDD will issue Medicaid Certification. Agencies can neither provide nor be reimbursed for services without Program Approval and Medicaid Certification. Provider enrollment information is available on the Colorado Department of Health Care Policy and Financing website: http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485906.

If the agency is applying for Initial Program Approval for Group Residential Services and Supports (GRSS) the agency must also contact the Colorado Department of Public Health and Environment (CDPHE) at 303.692.2881 to apply for a group home license.

If you have any questions, please contact Candie Dalton at 303.866.7904 or Candie.Dalton@state.co.us.

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Service Agency Name: _____

Address: _____ City _____ State _____ Zip _____

Mailing Address (if different): _____

E- Mail Address: _____

Phone Number(s): _____ Fax: _____

Name and Title of Agency Director/CEO: _____

The Service Agency is (check one):

[ ] An organization or business providing services or supports predominantly for persons with developmental disabilities

[ ] A community agency providing services predominantly to persons without developmental disabilities

Service(s) the agency is applying to provide:

- ☐ Assistive Technology (HCBS-SLS and HCBS-CES)
- ☐ Behavioral Supports (HCBS-DD, HCBS-SLS and HCBS-CES)
- ☐ Dental Services (HCBS-DD and HCBS-SLS)
- ☐ Home Accessibility Adaptations (HCBS-SLS and HCBS-CES)
- ☐ Homemaker Services (HCBS-SLS and HCBS-CES)
- ☐ Personal Emergency Response System (HCBS-SLS)
- ☐ Professional Services – Hippotherapy (HCBS-SLS and HCBS-CES)
- ☐ Professional Services – Massage Therapy (HCBS-SLS and HCBS-CES)
- ☐ Professional Services – Movement Therapy (HCBS-SLS and HCBS-CES)
- ☐ Transportation (HCBS-DD and HCBS-SLS)
- ☐ Vehicle Modifications (HCBS-SLS and HCBS-CES)
- ☐ Vision Services (HCBS-DD, HCBS-SLS and HCBS-CES)

For DDD Use Only Date Application Received: _____

_____Approved _____Incomplete _____Denied

Comments:

Service Agency Name: _____

Proposed Opening/Start Date: _____

Is the agency approved to provide services under another waiver(s)?
☐Yes ☐No If yes, which waiver(s)? _____

Identify the CCB(s) service area in which the agency is applying to provide services: _____

_____

Has the organization even been under prohibition or sanction from a contracting authority or licensing entity?
Yes ☐ No ☐ If yes, please explain: _____

_____

Agency Assurances - Please initial each assurance after it has been met.

The service agency assures:

_____All of the information submitted to the Division for Developmental Disabilities in support of its request for program approval is accurate. The agency will notify the Division for Developmental Disabilities of any change or reconfiguration to the program(s) and seek new program approval, if needed, prior to implementation of a change.

_____ Compliance with requests from the Division for Developmental Disabilities to update any information applicable to program approval.

_____The receipt of information on the three options for claims submission. Please attach the Claims Submission Process Selection form.

_____All staff members, including director, meet the minimum provider qualifications for the service to be provided and have all certifications and/or licensures required by the State of Colorado for the performance of the service or support being provided. Please submit copies of applicable professional licenses and/or certifications. Criminal background and references have been checked and are available for review.

_____Notification of CCB(s) and the Division for Developmental Disabilities when any action is taken against the provider's license.

_____The product or service to be delivered must meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards.

_____ Compliance with all applicable statutory and regulatory requirements and the Division for Developmental Disabilities' policies, guidelines, and advices including any subsequent changes.

_____Cooperation with Federal and State auditing authorities.

_____Cooperation with and response to on-site Program Quality visits, matters of inquiry and plans of correction as may be required by the Division for Developmental Disabilities.

_____ The provision of services and submission of claims only for services the agency is qualified and approved to provide.

_____Immediate reporting of all suspected cases of abuse, neglect, exploitation and mistreatment to the Community Centered Board and when appropriate, to law enforcement, Adult Protective Services and/or Child Protective Services.

I certify that I have read and am familiar with all rules and statute regulating developmental disabilities services and I agree to fully comply with them. Further more, I certify all information provided as part of this application is accurate and all assurances have been completed. Documentation that demonstrates the assurances have been met is on file at the agency's administrative office and available for review.

_____ _____

Executive Director Signature Date

_____ _____

Board President Signature, if applicable Date

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PROGRAM APPROVED SERVICE AGENCY CLAIM SUBMISSION PROCESS SELECTION

All Program Approved Service Agencies (PASA) are required to obtain a Medicaid Provider Number by submitting a Colorado Medical Assistance Provider Application to ACS, the fiscal agent for the Department of Health Care Policy and Financing.

As a Medicaid Provider the following options are available for claim submission. Please initial the option the prospective service agency has chosen.

_____ Option 1 – Submit claims directly to ACS, the Medicaid fiscal agency, though MMIS (Medicaid Management Information System). *The PASA is responsible for correct submission of claims and completing any follow-up for denied or incorrectly paid claims.*

_____ Option 2 – Utilize a business/billing agent to submit claims. *The PASA contracts with a business/billing agent to conduct the claim submission functions. This may include completing any follow-up for denied or incorrectly paid claims.*

Business/Billing Agent Name:_____
Address:_____
Phone:_____

_____ Option 3 – Subcontract with the Community Centered Board (CCB) as the Organized Health Care Delivery System (OHCDS.) *The CCB is responsible to follow-up on denied or incorrectly paid claims.*

The PASA must maintain documentation to support all submitted claims.

_____ _____
Signature of PASA Director Date

_____ _____
Signature of CCB Executive Director or Designee Date
(If Option 3 is selected)

Initial Program Approval Application Submission Requirements

Prospective Program Approval Service Agencies must submit the following with the Program Approval application:

- Resume or Curriculum Vitae with complete work history for owner/director/operator, director and associate director as applicable.
- Copies of any relevant licenses or certifications as requested.
- Copy of the agency's by-laws.
- Articles of Incorporation.
- Listing of the membership of the board of directors or trustees of the agency along with their affiliations, as applicable.
- Detailed organizational chart including staff identified for positions.
- Claims Submission Process Selection form.
- A business plan that includes, at minimum, the following:
    - § Description of the services to be provided.
    - § Specific population to be served.
    - § Location of services.
    - § What are the specific outcomes for persons with developmental disabilities as the result of participation in this program?
- Description of your working experience with people with developmental disabilities.
- Description of how staff will be recruited, hired, trained and evaluated.
- Description of organizational structure, including the roles of any advisory boards. Out-of-State corporations are required to develop local advisory board as set forth in 2 CCR 503-1 16.222 B.
- Certificate of Good Standing from the Colorado Secretary of States office.